

<b>TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL</b> FOR: CENTER FOR MEDICARE AND MEDICAID SERVICES	1. TRANSMITTAL NUMBER <b>03-07</b>	2. STATE: <b>ILLINOIS</b>
	3. PROGRAM IDENTIFICATION: <b>Title XIX of the Social Security Act (Medicaid)</b>	
TO: REGIONAL ADMINISTRATOR CENTERS FOR MEDICARE AND MEDICAID SERVICES DEPARTMENT OF HEALTH AND HUMAN SERVICES	4. PROPOSED EFFECTIVE DATE: <b>July 1, 2003</b>	

5. TYPE OF PLAN MATERIAL (Check One)

☐ NEW STATE PLAN      ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN      ☒ AMENDMENT

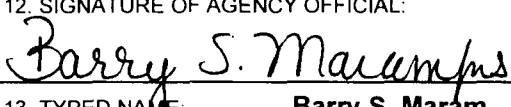
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: Section 1902 (a) Social Security Act	7. FEDERAL BUDGET IMPACT a. FFY '03 \$ (650,000) b. FFY '04 \$ (2.5M)
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  Attachment 4.19-C, page 1	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  Attachment 4.19-C, page 1

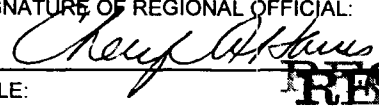
10. SUBJECT OF AMENDMENT: **Payment Policy for Reserving Beds in Inpatient Facilities**

11. GOVERNOR'S REVIEW (Check One)

- ☐ GOVERNOR'S OFFICE REPORTED NO COMMENT  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL  
☒ OTHER, AS SPECIFIED: Not submitted for review by prior approval.

12. SIGNATURE OF AGENCY OFFICIAL: 	16. RETURN TO: <b>Illinois Department of Public Aid Bureau of Program and Reimbursement Analysis Attn: Frank Kopel, Chief 201 South Grand Avenue East Springfield, IL 62763-0001</b>
13. TYPED NAME: <b>Barry S. Maram</b>	
14. TITLE: <b>Director of Public Aid</b>	
15. DATE SUBMITTED	

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:	18. DATE APPROVED: <b>12/3/03</b>
PLAN APPROVED—ONE COPY ATTACHED	
19. EFFECTIVE DATE OF APPROVED MATERIAL:	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME	22. TITLE: <b>RECEIVED</b>
23. REMARKS: <b>RECEIVED SEP 30 2003 DMCH - ILL/IN/CH</b>	

State Illinois

PAYMENT POLICY FOR RESERVING BEDS IN INPATIENT FACILITIES

07/02 Bed reserve is allowed for all Medicaid group care residents of nursing facilities as follows:

= 07/03 Payment for bed reserve is allowed for ~~hospitalization and~~ home visits. All bed reserve requests must:

- be authorized by a physician;
- be limited to residents who desire to return to the same facility; and
- be limited to facilities that have a 93 percent or higher occupancy level.

= 07/03 ~~Payment for bed reserve is allowed for resident hospitalization not exceeding ten (10) days per hospital stay. The day the resident is transferred to the hospital is the first day of the reserve period.~~

07/02 Payment for bed reserve is allowed for a home visit when a physician indicates the home visit is therapeutically beneficial for the resident. Bed reserve is limited to seven (7) consecutive days in a calendar month or ten (10) nonconsecutive days within a calendar month. Home visits may be extended with the approval of the Department.

Bed reserve days for home visits are computed on a midnight basis. If a resident is in the facility any part of the day, it is not counted as a bed reserve day and the facility will receive the resident's current Medicaid per diem.

07/02 Payment for approved bed reserve is a daily rate of 75 percent of a resident's current Medicaid per diem.

In no facility is the number of vacant beds to be less than the number of beds identified for residents allowed bed reserve. The number of vacant beds in the facility must be equal to or greater than the number of residents allowed bed reserve.

TN # 03-07

APPROVAL DATE DEC 1 2003

EFFECTIVE DATE 07-01-03

SUPERCEDES

TN # 02-27